

**BEFORE THE IOWA BOARD OF MEDICINE**

\*\*\*\*\*

**IN THE MATTER OF THE STATEMENT OF CHARGES AGAINST**

**BETH M. WINKE, M.D., RESPONDENT**

**FILE No. 02-13-328**

\*\*\*\*\*

**STATEMENT OF CHARGES and SETTLEMENT AGREEMENT  
(Combined)**

\*\*\*\*\*

COMES NOW the Iowa Board of Medicine (Board) and Beth M. Winke, M.D., (Respondent), on December 20, 2013, and pursuant to Iowa Code sections 17A.10(2) and 272C.3(4) and 653 IAC 25.3, enter into this combined Statement of Charges and Settlement Agreement.

**STATEMENT OF CHARGES**

1. Respondent was issued Iowa medical license no.27429 on January 252, 1990.
2. Respondent's Iowa medical license went inactive due to nonrenewal on July 1, 1996.
3. The Board has jurisdiction in this matter pursuant to Iowa Code chapters 147, 148 and 272C.

## COUNT I

4. **Discipline by Another Licensing Authority:** Respondent is charged pursuant to Iowa Code section 148.6(2)(d) and 653 IAC 23.1(1) with having a license to practice medicine and surgery or osteopathic medicine and surgery revoked or suspended, or having other disciplinary action taken by a licensing authority of another state, territory, or country. A certified copy of the order of disciplinary action is prima facie evidence.

### STATEMENT OF THE MATTERS ASSERTED

5. Respondent is an Iowa-licensed physician who currently practices pain management in Virginia Beach and Carrollton, Virginia

6. **Virginia Disciplinary Action:** On or about May 20, 2013, Respondent was disciplined by the Virginia Board of Medicine (Virginia Board). The Virginia Board alleged that Respondent failed to provide appropriate medical care to multiple patients between May 2006 and January 2011, when she:

- A. Failed to perform adequate physical examinations on multiple patients who she was treating for chronic pain management;
- B. Failed to request or obtain records, including results of diagnostic testing and/or operative reports, from prior treatment providers and/or coordinate care with concurrent treatment providers before prescribing narcotics for these patients' complaints of chronic pain;
- C. Failed to review/address urine drug screen results for multiple patients; and

- D. Inappropriately prescribed or authorized refills of narcotic medications for a patient prior to the time that it should have been needed if the medications had been taken as directed.

The Virginia Board ordered Respondent to pay a \$1,000 fine. See Attachment A.

### **SETTLEMENT AGREEMENT**

7. **VOLUNTARY SURRENDER:** Respondent voluntarily surrenders her Iowa medical license to resolve this matter.

8. Respondent voluntarily submits this Order to the Board for consideration.

9. Respondent agrees that the State's counsel may present this Order to the Board for consideration.

10. By entering into this Order, Respondent understands that he has a right to be represented by legal counsel, voluntarily waives any rights to a contested case hearing on the allegations in the Statement of Charges, and waives any objections to the terms of this Order. This Order constitutes the resolution of a contested case proceeding.

11. Respondent understands that by entering into this combined Statement of Charges and Settlement Agreement, Respondent cannot obtain a copy of the investigative file. Pursuant to Iowa Code section 272C.6(4), a copy of the investigative file may only be provided to a licensee after a Statement of Charges is filed but before the final resolution of those charges.


12. Respondent shall obey all federal, state and local laws, and all rules governing the practice of medicine in Iowa.

13. Respondent understands that the Board is required by Federal law (45 C.F.R. 60.8) to report this Order to the National Practitioner Data Bank.

14. This Order becomes a public record available for inspection and copying upon execution in accordance with the requirements of Iowa Code Chapters 17A, 22 and 272C.

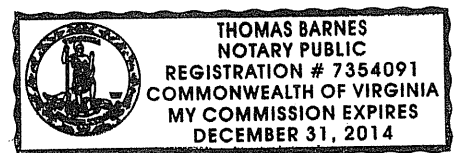
15. This Order is subject to approval of the Board. If the Board fails to approve this Order it shall be of no force or effect to either party.

16. The Board's approval of this Order shall constitute a **Final Order** of the Board.

  
Beth M. Winke, M.D., Respondent

Subscribed and sworn to before me on 9-27, 2013.

Notary Public, State of Virginia.



This Order is approved by the Board on December 20, 2013.

A handwritten signature in black ink, appearing to read "G. Hoversten". The signature is fluid and cursive, with a large initial "G" and a stylized "H".

---

Gregory B. Hoversten, D.O., Chairman  
Iowa Board of Medicine  
400 SW 8<sup>th</sup> Street, Suite C  
Des Moines, Iowa 50309-4686

VIRGINIA:

BEFORE THE BOARD OF MEDICINE

IN RE:       BETH M. WINKE, M.D.  
              License No.: 0101-054160

ORDER

In accordance with Sections 54.1-2400(10), 2.2-4019 and 2.2-4021 of the Code of Virginia (1950), as amended ("Code"), an informal conference was held with Beth M. Winke, M.D., on April 10, 2013, in Henrico, Virginia. Members of the Virginia Board of Medicine ("Board") serving on the Special Conference Committee ("Committee") were: J. Randolph Clements, D.P.M, Chair; Robert Hickman, M.D.; and Jane Sheffield Maddux. Dr. Winke appeared personally and was not represented by legal counsel. Dale P. Lutke, Adjudication Specialist, was present as a representative for the Administrative Proceedings Division of the Department of Health Professions.

The purpose of the informal conference was to inquire into allegations that Dr. Winke may have violated certain laws governing the practice of medicine in the Commonwealth of Virginia, as set forth in a Notice of Informal Conference dated March 8, 2013.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Now having properly considered the evidence and statements presented, the Committee makes the following Findings of Fact and Conclusions of Law in this matter:

1. Beth M. Winke, M.D., was issued license number 0101-054160 by the Board to practice medicine and surgery in the Commonwealth of Virginia on May 31, 1996. Said license is currently active and will expire on July 31, 2014, unless renewed or otherwise restricted.

2. Dr. Winke violated Section 54.1-2915.A(3) of the Code in that from approximately May 2006 to in or about January 2011, she failed to perform adequate physical examinations for Patient A and Patients D-G, who she was treating for chronic pain management. Specifically, information consistently recorded in the "physical examination" section of her office notes related mainly to observations regarding the patients' affect, posture, gait, and the presence of any assistive devices.

3. Dr. Winke stated that, during the above timeframe, she was an employee of a sports medicine practice where she provided care and treatment along with other practitioners in the office (e.g., orthopedic specialists, physical therapists). Some patients were seen every month for up to 10 years. Dr. Winke explained that, as part of the group practice, she performed "focused orthopedic examinations" for these patients rather than traditional medical examinations. Because she had been their provider for many years, Dr. Winke recalled that the patients' files contained hand-written notes that were not provided by the sports medicine practice to Dr. Winke when the patients transferred to her solo practice in 2010. Although she requested the prior treatment records from the sports medicine practice, she failed to document that request. Currently, as a solo practitioner treating pain management patients, Dr. Winke stated she always conducts and documents a thorough physical examination of her patients and forwards a copy of her records to the patient's primary care provider. Additionally, she tries diligently to get records from other treatment providers.

4. Dr. Winke violated Section 54.1-2915.A(16) of the Code in the care and treatment of Patient A and Patients F-H from in or about August 2003 to in or about January

2011 in that she failed to request or obtain records, including results of diagnostic testing and/or operative reports, from prior treatment providers and/or coordinate care with concurrent treatment providers before prescribing narcotics for these patients' complaints of chronic pain.

5. Dr. Winke stated that after she became a solo practitioner in February 2010, which allows her maintain control over her practice and its administrative processes. She also she implemented internal policies and protocols regarding the collection of prior treatment medical records. She has implemented an electronic medical record ("EMR") process, whereby she records requests for prior records in the patient's EMR leaving the "case" open until the records are received. Dr. Winke noted that her staff spends a significant amount of time working to obtain records from other health practitioners, but noted that she does not have control over the information other practitioners provide to her, therefore, this information may not be complete.

6. Dr. Winke violated Sections 54.1-2915.A(3) and (17) and 54.1-3408(A) of the Code in that she failed to review/address urine drug screen ("UDS") results when, on the following dates, Patients B and E tested negative for metabolites of medications prescribed by Dr. Winke, which initially indicated that the medications had not been taken as prescribed: October 4, 2010 (Patient B); June 2, 2009; July 17, 2009; and October 4, 2010 (Patient E).

7. Dr. Winke explained that, in October 2010, she initially gave Patient B the benefit of the doubt in thinking he may have taken the medications just prior to the office visit, which would explain the negative metabolite result. In 2011, Patient B again tested



negative for metabolites of the prescribed medications and a later UDS tested negative for the metabolites and positive for methadone. Patient B was discharged from further treatment in June 2012, approximately 20 months after the October 4, 2010 UDS result. According to Dr. Winke, at that point in her practice, there was a learning curve involved in understanding the lab results and the importance of the metabolites. She assured the Committee that, in her current practice, if the patient tests negative for the metabolites of prescribed medications, she requires that the patient be seen for a pill count to determine if they are compliant with the medication regimen. Dr. Winke stated she now has a better understanding of the testing and is willing to dismiss patients whose UDS results are inconsistent with the medications that are prescribed.

8. Dr. Winke violated Sections 54.1-2915.A(3) and (17) and Section 54.1-3408(A) of the Code in that she regularly prescribed or authorized refills of narcotic medications for Patient C prior to the time that should have been needed if the medications had been taken as directed. Further, Dr. Winke concomitantly prescribed multiple narcotic medications to Patient C..

9. Dr. Winke explained she saw most of the patients discussed above, including Patient C, for many years in her prior sports medicine practice and their care transferred to her when she became a solo practitioner. Further, she informed the Committee that Patient C had been discharged from further treatment prior to the Department of Health Professions' investigation when a subsequent UDS tested positive for cocaine.

10. Dr. Winke stated that she has made changes in her current practice to ensure that none of the issues raised in this case will occur in the future. She has improved

documentation by implementing an EMR. She now utilizes pain management contracts and enforces those contracts. She has an internal protocol for urine drug testing of all pain management patients where the degree of substance abuse risk determines the frequency of testing. Should any patients fail to comply with the treatment regimen, they are subject to dismissal from the practice.

11. The Committee determined that Dr. Winke has made substantial changes in her pain management practice to address the deficiencies noted several years ago. Thus, she has appropriately addressed the concerns the Committee had regarding her pain management practice.

#### ORDER

WHEREFORE, based on the above Findings of Fact and Conclusions of Law, it is hereby ORDERED that Dr. Winke pay a MONETARY PENALTY in the amount of one thousand dollars (\$1000). The monetary penalty shall be paid to the Board within forty-five (45) days from entry of this Order. Failure to pay the full monetary penalty within the timeframe stipulated may constitute grounds for an administrative proceeding.

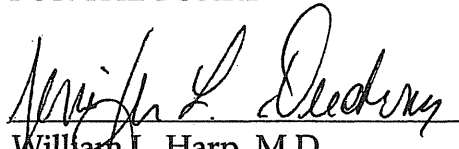
Dr. Winke shall maintain a course of conduct in the practice of medicine commensurate with the requirements of Title 54.1, Chapter 29 of the Code and all laws of the Commonwealth.

Pursuant to Sections 2.2-4023 and 54.1-2400.2 of the Code, the signed original of this Order shall remain in the custody of the Department of Health Professions as a public record, and shall be made available for public inspection and copying upon request.

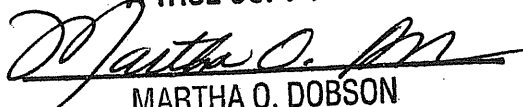
Pursuant to Section 54.1-2400(10) of the Code, Dr. Winke may, not later than 5:00 p.m., on May 20, 2013, notify William L. Harp, M.D., Executive Director, Board of Medicine, 9960 Mayland Drive, Suite 300, Henrico, Virginia 23233, in writing that she desires a formal administrative hearing before the Board. Upon the filing with the Executive Director of a request for the hearing, this Order shall be vacated.

Therefore, this Order shall become final on May 20, 2013; unless a request for a formal administrative hearing is received as described above.

FOR THE BOARD

  
William L. Harp, M.D.  
Executive Director  
Virginia Board of Medicine  
ENTERED: 4/16/13

A TRUE COPY TESTE:

  
MARTHA O. DOBSON  
DISCIPLINE SPECIALIST  
VIRGINIA BOARD OF MEDICINE